



Office use only:
Date: _____
Exam Room: _____
Moderator: _____
Alt.ID# _____

Baseline Worksheet

I. Demographic and Background Information

General Information

Name _____ **DOB** _____

SS# ____ -- ____ -- ____ **Height** ____ **Weight** _____

School/ Organization _____

Handedness: R *or* L *or* Both **Gender:** Male *or* Female

Language

Native Language _____

Education

Years of Education Completed (e.g., high school senior is 11 years) _____ years

Check any of the following that apply:

- Received speech therapy
- Attended special education classes
- Repeated one or more years of school
- Diagnosed attention deficit disorder or hyperactivity
- Diagnosed learning disability

Sports

Current Sport: _____

position/ event/ class _____

level of participation _____

(e.g.: high school, semi-professional, collegiate etc)

years of experience at this level: _____

(approximate if needed; e.g., high school senior is 3 years)

Concussion History

Number of times diagnosed with a concussion: _____

Total number of concussions that have resulted in loss of consciousness

- Total number of concussions that resulted in confusion.
- Total number of concussions that resulted in difficulty with memory of events occurring immediately after injury.
- Total number of concussions that resulted in difficulty with memory of events occurring immediately before injury.
- Total number of games that were missed as a result of concussions

Please List your five most recent concussions: _____
(use approximate dates if needed) _____

Indicate whether you have experienced the following:

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Treatment for headaches by physician |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Treatment for migraine headaches by physician |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Treatment for epilepsy/ seizures |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | History of brain surgery |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | History of meningitis |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Treatment for substance/ alcohol abuse |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Treatment for psychiatric condition (depression, anxiety etc.) |

II. Current symptoms and conditions

Date of last concussion: ____ - ____ - ____ **(month- day- year)**

Total hours of sleep last night: _____ hours

Current medications: _____

Please check the box below that indicates the degree to which you are CURRENTLY experiencing the following symptoms:

No symptoms "0"-----Moderate "3"-----Severe "6"

Headache	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6
Nausea	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6
Vomiting	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6
Balance problems	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6
Dizziness	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6
Fatigue	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6
Trouble falling to sleep	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6
Excessive sleep	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6
Loss of sleep	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6
Drowsiness	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6
Light sensitivity	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6
Noise sensitivity	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6
Irritability	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6
Sadness	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6
Nervousness	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6
More emotional	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6
Numbness	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6
Feeling "slow"	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6
Feeling "foggy"	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6
Difficulty concentrating	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6
Difficulty remembering	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6
Visual problems	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6

****Please leave all paperwork in clinical testing room when completed**

**** All remaining portions of the test will be performed in a clinical room**

III. Neurocognitive Testing (computerized baseline)

- **Module 1- Word Discrimination**
- **Module 2- Design Memory**
- **Module 3- X's and O's**
- **Module 4- Symbol Matching**
- **Module 5- Color Matching**
- **Module 6- Three Letters**